

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01361

## CERTIFICATE OF DEATH

Reg. Dist. No. 2970

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Fannie Butler Baker

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female white widow

6. (b) Name of husband or wife

John W. Baker

7. Birth date of deceased (mo., day, yr.)

Oct. 22, 1862

8. AGE:

Years

84

Months

5

Days

10

If less than one day

hrs. min.

9. Birthplace

Trappe Talbot Co., Md.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

John Schuyler

MOTHER FATHER

12. Name

Trappe, Talbot Co., Md.

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

City or town.....

Street No.....

2.(a) If veteran, name war.....

(If rural, give LOCATION)

3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 1, 1947, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 28, 1947, to April 1, 1947

and that I last saw h.w. alive on April 30, 1947

Immediate cause of death

Acute myocarditis

Due to

Bronch.-pneumonia

Due to

Influenza

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

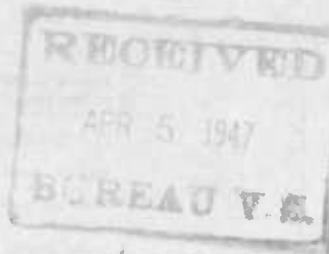
Means of injury Injured at work?

23. SIGNATURE

Joseph A. Ross M. D. on other

Address

Date signed 4/1/47



1-35

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 172

01362

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

## 1. PLACE OF DEATH:

County..... Talbot County  
 City or town..... St. Michaels, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Edward D. Baynard, Jr.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

B. (b) Name of husband or wife.....

B. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

April 24, 1937

8. AGE:

Years	Months	Days	If less than one day
10	0	3	hrs. min.

B. Birthplace..... Memorial Hospital, Easton, Md.  
 (Town, county, and state) Child

10. Usual occupation.....

11. Industry or business

12. Name..... Edward D. Baynard

13. Birthplace..... Greensboro, Md.

14. Maiden name..... Anna V. Kemp

15. Birthplace..... St. Michaels, Md.

16. Informant..... Edward M. Baynard

Address..... St. Michaels, Md.

17. Burial

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

April 30, 1947

Cemetery or crematory..... Olivet Cemetery

Location..... St. Michaels, Md.

18. Funeral director..... Newnam &amp; Harrison

Address..... St. Michaels, Md.

19. April 29, 1947  
 (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Talbot

City or town..... St. Michaels, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 27

1947, at C. 130 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Accidental drowning

Due to..... Fire in boat

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... accident Date of..... 4-27-47

Where did injury occur? St. Michaels Talbot (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) river

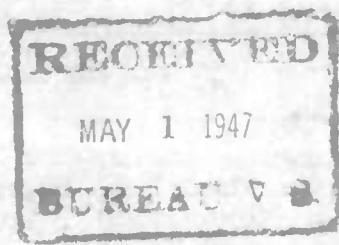
Means of injury..... drowning Injured at work? no

23. SIGNATURE

Louis D. McElroy, M.D. D.P.M. M.D. or other

Address..... Easton, Md.

Date signed..... April 29, 1947



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17)

01363

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:  
County Talbot County

City or town St. Michaels, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

James M. Baynard

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>
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6. (b) Name of husband or wife.....

7. Birth date of  
deceased (mo., day, yr.) July 8, 1940

8. AGE: Years <u>6</u>	Months <u>8</u>	Days <u>19</u>	It less than one day ..... hrs. ..... min.
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9. Birthplace Memorial Hospital, Easton, Md.  
(Town, county, and state)

10. Usual occupation Child

11. Industry or business

12. Name <u>Edward D. Baynard</u>
13. Birthplace <u>Greensboro, Md.</u>

14. Maiden name <u>Anna V. Kemp</u>
15. Birthplace <u>St. Michaels, Md.</u>

16. Informant Edward M. Baynard  
Address St. Michaels, Md.

17. Burial Burial Date thereof April 30, 1947  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Olivet Cemetery  
Location St. Michaels, Md.

18. Funeral director Newnam & Harrison  
Address St. Michaels, Md.

19. April 29 19 47 Miss. Rose L. Sotth  
(Date rec'd by registrar) Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Talbot

City or town St. Michaels, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. ..... (If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number None

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 27 19 47 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated: Not attended deceased from 19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death.....

Accidental drowning Imm.

Due to Fire on boat

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

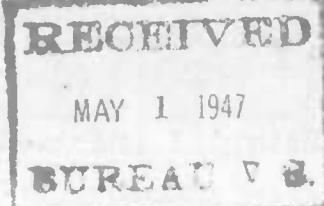
Accident, suicide, or homicide accident Date of 4-27-47

Where did injury occur? St. Michaels Talbot Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) river

Means of injury drowning Injured at work? no

23. SIGNATURE John J. Neely, M.D. Dept. of Health  
M. D. or other Easton, Md.  
Address Easton, Md. Date signed 4-29-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

## CERTIFICATE OF DEATH

01364

294

Reg. Dist. No.

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Wm. Brooks

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

Col.

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age .....

years

1924

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

23

9. Birthplace

(Town, county, and state)

Wilmington Del.

10. Usual occupation

factory worker

11. Industry or business

Packing house

12. Name

MOTHER

FATHER

13. Name

14. Maiden name

15. Birthplace

16. Informant

Address

17. (Burial, cremation, or removal, Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. Date rec'd by registrar

Date thereof (month) (day) (year)

4-22-47

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 18

1947, at 10:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Wilmington Del. 9:15 a.m. to April 18, 1947, and that I last saw him alive on April 18, 1947.

Immediate cause of death

Diseased

DURATION

Over

Due to

Cancer

Over

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Signature Date signed

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APR 25 1947

BUREAU

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

**CERTIFICATE OF DEATH**

01365

Reg. Diat. No. ....

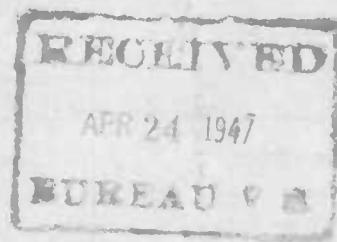
1. PLACE OF DEATH: County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... County..... City or town..... (If outside city or town limits, write RURAL and give nearest town)			
How long in above place of death?..... Hospital, Institution, or Street address where death occurred:..... How long in hospital or institution?.....				Street No. .... (If rural, give LOCATION)			
3. (a) FULL NAME <b>Carmine, George C.</b>				2.(a) If veteran, name war..... 3. (b) Social Security Number			
4. Sex <b>M</b>		5. Color or race <b>W</b>		6.(a) Single, married, widowed, or divorced <b>Married</b>		MEDICAL CERTIFICATION	
B.(b) Name of husband or wife <b>Edna Carmine</b>		6.(c) If alive, give age..... years		20. DATE OF DEATH <b>April 17, 1947</b>		at <b>10 AM</b>	
7. Birth date of deceased (mo., day, yr.) <b>Oct. 8, 1865</b>		8. AGE: Years <b>81</b> Months Days If less than one day hrs. .... min.		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <b>Apr 6 1947 to Apr 7 1947</b> and that I last saw him alive on <b>Apr 7 1947</b>		DURATION <b>3 days</b>	
9. Birthplace <b>Preston - Caroline Co., Md.</b> (Town, county, and state)		10. Usual occupation <b>Rear Admiral, Coast Guard</b>		Immediate cause of death <b>Pneumonia Edema - Bronchial</b>		Due to <b>Sclerotic kidneys</b>	
11. Industry or business <b>Capt. Charles Carmine</b>		12. Name <b>Edna Carmine</b>		13. Birthplace <b>Md.</b>		Due to <b>arterio sclerosis</b>	
14. Maiden name <b>Mary Faighston</b>		15. Birthplace <b>Md.</b>		Other conditions <b>Diverticulosis of colon</b>		Due to <b>Hyper trophy of prostate</b>	
16. Informant <b>Mrs. Edna Carmine</b>		17. Date thereof <b>April 11, 1947</b> (Burial, cremation, or removal. Which?)		18. Cemetery or crematory <b>Burial Arlington</b>		(Include pregnancy within 3 months of death)	
Address <b>Preston, Md.</b>		(Month) (day) (year) <b>Apr 11 1947</b>		Location <b>Washington, D.C.</b>		Major findings of operations <b>None</b>	
19. Funeral director <b>J. H. Tolson</b>		Address <b>Preston, Md.</b>		Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.		Date of op.	
Address <b>Preston, Md.</b>		20. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide.....		Where did injury occur?.....		Date of.....	
Address <b>Preston, Md.</b>		21. Injured at home, farm, industry, public place (where?).....		(City or town).....		(County).....	
Address <b>Preston, Md.</b>		22. Means of injury.....		Injured at work?.....		(State).....	
Address <b>Preston, Md.</b>		23. SIGNATURE <b>John Schneider</b>		Address <b>Easton, Md.</b>		M. D. on <b>Apr 9, 1947</b>	
Address <b>Preston, Md.</b>		(Date rec'd by registrar) <b>4/8 1947</b>		Address <b>Easton, Md.</b>		Date signed <b>Apr 9, 1947</b>	
Address <b>Preston, Md.</b>		Registrar		Address <b>Easton, Md.</b>		Address <b>Easton, Md.</b>	

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

B.P.

## CERTIFICATE OF DEATH

01367

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... Talbot

City or town..... St. Michaels

(If outside city or town limits, write RURAL and give nearest town)

50 years

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

John R. Dawson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male

white

married

6. (b) Name of husband or wife

Lucy Dean

7. Birth date of deceased (mo., day, yr.)

Sept. 3, 1856

8. (c) If alive, give age..... 70 years

8. AGE: Years

Months

Days

If less than one day

90

6

29

hrs.

min.

9. Birthplace.....

Centerville, Maryland

(Town, county, and state)

10. Usual occupation.....

Salesman

11. Industry or business

Ianas Dawson

FATHER

MOTHER

12. Name.....

Church Hill, Md.

13. Birthplace.....

Jane Dillon

14. Maiden name.....

15. Birthplace.....

Church Hill, Md.

16. Informant.....

Mrs. John R. Dawson

Address

St. Michaels, Md.

17. Burial.....

Date thereof..... April 5, 1947

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Olivet Cemetery

Location.....

St. Michaels, Md.

18. Funeral director.....

Newnam &amp; Harrison

Address

St. Michaels, Md.

19. (Date rec'd by registrar)

19

Date rec'd by registrar

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland

County.....

Talbot

City or town..... St. Michaels

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 2, 1947

19..... 6.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 26, 1947, to April 2, 1947

19

and that I last saw him alive on April 1, 1947

19

Immediate cause of death..... Hernia

DURATION

3 days

Due to..... terminal stage chronic nephritis - no renal function

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

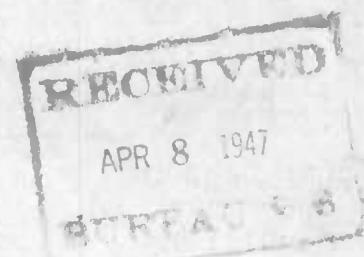
Means of injury.....

Injured at work?.....

23. SIGNATURE..... S. Denney Wallen, M.D.

M. D. or other

Address..... St. Michaels, Md. Date signed..... 4/2/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01368

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 292

## 1. PLACE OF DEATH:

County TalbotCity or town Oxford

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Mary Ogden Driggs

4. Sex

5. Color of face

6. (a) Single, married, widowed, or divorced

F. W. Undiv.

6. (b) Name of husband or wife

Lawrence A. Driggs

7. Birth date of deceased (mo., day, yr.)

Oct. 14, 1875

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
71	6	5	hrs. min.

9. Birthplace

Mary.

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Alfred Ogden

12. Name

Alfred Ogden

13. Birthplace

Oxford, Md.

14. Maiden name

Mabel Trebilcot

15. Birthplace

Mary.

16. Informant

Ogden Driggs

Address

Oxford, Md.

17. Cremation

(Burial, cremation, or removal. Which?)

Date thereof April 19, 1947

(month) (day) (year)

Cemetery or crematory

Cedar Point Cemetery

Location

Wilmington, Del.

18. Funeral director

Robert Clark

Address

Oxford, Md.

19. April 19, 1947

(Date rec'd by registrar)

Joseph A. Rocco

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County TalbotCity or town Oxford

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1947 at 6:45 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 19, 1947 to 19, 1947 and that I last saw her alive on 18 April 1947 1947Immediate cause of death Cerebral Hemorrhage

DURATION

3 weeksDue to Cerebral arteriosclerosis

Due to

Other conditions Hypertension and Cardiac failure

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

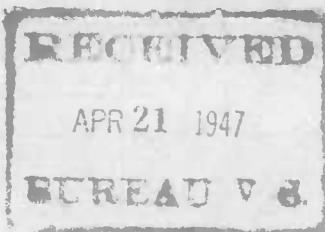
Injured at work?

23. SIGNATURE

Robert Harrison M.D.

M. D. or other

Address 2048, Grove St. Elkhorn Date signed 19 April 1947



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 402

## CERTIFICATE OF DEATH

Reg. Dist. No. 01369

## 1. PLACE OF DEATH

County

City or town

Talbot

Oxford

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ida Green

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

f

col.

Widow

6. (b) Name of husband or wife

Edward Green

(b) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

Oct. 8, 1883

deceased (mo., day, yr.)

Years

Months

Days

If less than one day

63

8

1

hrs.

min.

8. AGE:

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Location

18. Funeral director

Address

19. (Date rec'd by registrar)

Date of death

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

City or town

Street No.

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 9

1947 at 2A: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 6 1946 to April 9 1947

and that I last saw deceased alive on April 9 1947

Immediate cause of death

Drgmssnse of the Colon

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hayward T. Webb, M.D. M. D. or other

Address Date signed 4/9/47

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APR 21 1947

BUREAU F. B. I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-1)

Ball 01370  
Harrison

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH: *Jaehat*  
County: *Easton*  
City or town: *Easton* (If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death: *5 1/2 years*  
Hospital, Institution, or street address where death occurred: *206 August St.*  
How long in hospital or Institution:

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State: *MD* County: *Jaehat*  
City or town: *Easton* (If outside city or town limits, write RURAL and give nearest town)  
Street No.: *206* Street: *August* (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number  
*None*

3. (a) FULL NAME

*Grace M. Harrison*  
4. Sex: *Female* 5. Color or race: *White* 6.(a) Single, married, widowed, or divorced: *Married*  
Name of husband or wife: *J. Olin Harrison*  
7. Birth date of deceased (mo., day, yr.): *Apr. 21, 1890* 60 years  
8. AGE: Years: *53* Months: *11* Days: *24* If less than one day: *hrs. 00* min. 00  
9. Birthplace: *Royal Oak (Rural) Md.* (Town, county, and state)  
10. Usual occupation: *Housewife*

11. Industry or business:

12. Name: *Levin G. Gilman*  
13. Birthplace: *Royal Oak Md.*  
14. Maiden name: *Sarah K. Harrison*  
15. Birthplace: *Dearborn Md.*  
16. Informant: *Mr. J. Olin Harrison*  
Address: *Easton, Md.*

17. Burial (Burial, cremation, or removal. Which?) *Burial* Date thereof: *Apr. 16, 1947*  
(month) (day) (year)

Cemetery or crematory: *Spring Hill Cemetery*  
Location: *Easton, Md.*  
18. Funeral director: *Maurice C. Deveraux, Jr.*  
Address: *Easton, Md.*

19. *4/14* 19 *47* N. R. Neeress  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: *13 April* 19 *47* at 8:00 M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *1947* to *1947* and that I last saw her alive on *13 April* 19 *47*

Immediate cause of death:

*Carcinoma of the uterus*

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

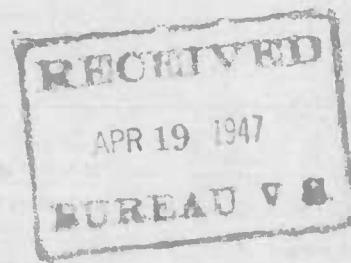
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

John Harrison, M.D.  
M. D. or other  
Address: *25 E. Main St. Easton, Maryland*  
Date signed: *Apr. 14, 1947*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-2

01371

## CERTIFICATE OF DEATH

Reg. Date No. 290

## 1. PLACE OF DEATH:

County TalbotCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 1/2 hours

Hospital, institution, or street address where death occurred:

Hospital - Easton, MarylandHow long in hospital or institution? 28 1/2 hours

## 3. (a) FULL NAME

Mr. Fred Jacobs4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Mrs. Annie Talbot7. Birth date of deceased (mo., day, yr.) Oct. 28, 1883 8. (c) If alive, give age 47 years8. AGE: Years 63 Months 5 Date 14 If less than one day hrs. min.9. Birthplace Harmon, Caroline, Md. (Town, County, and state)10. Usual occupation Farming

## 11. Industry or business

12. Name Fred Jacobs13. Birthplace Maryland14. Maiden name Julia Campers15. Birthplace Maryland16. Informant Mrs. Annie L. JacobsAddress Williamsburg (Md R)17. Burial, cremation, or removal (which?) Burial Date thereof 4/15/47 (month) (day) (year)Cemetery or crematory ConcordLocation near Federalsburg Md18. Funeral director J. J. Chapman SonsAddress Federalsburg Md.19. 4/14 19. 47 20. N. S. Dennis

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County DorchesterCity or town Rural - H. Lock (If outside city or town limits, write RURAL and give nearest town)Street No.  (If rural, give LOCATION)2.(a) If veteran, name war 

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 12 1947 at 10:15 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 1947 to April 12 1947and that I last saw him alive on April 12 1947Immediate cause of death Pulmonary EdemaEx. High Tension Cardiac DiseaseDuration 24 hoursDeath Cerebral HemorrhageDue to Chronic Hypertension CardioRenal Disease

5 days

Other conditions 

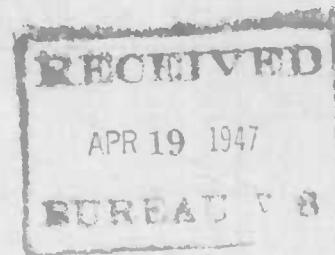
(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results Done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE Judy Dennis M. D. or other Address Frederick, Maryland Date signed 4/15/47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01372

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

1. PLACE OF DEATH:  
County..... **Talbot**

City or town..... **St. Michaels**  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... **Life**

Hospital, Institution, or street address where death occurred:  
.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

**Lorena Mae Johnson**

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	color	child

6. (b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)  
..... **Dec. 28, 1945**

8. AGE: Years	Months	Days	It less than one day
1	3	11	..... hrs. ..... min.

9. Birthplace..... **St. Michaels**  
(Town, county, and state)

10. Usual occupation..... **child**

11. Industry or business

FATHER 12. Name..... **Harold Johnson**  
13. Birthplace..... **Bellevue, Md.**

MOTHER 14. Maiden name..... **Pearl Jackson**  
15. Birthplace..... **St. Michaels, Md.**

16. Informant..... **Harold Johnson**  
Address..... **St. Michaels, Md.**

17. Burial (Burial, cremation, or removal. Which?)  
..... **Cemetery**  
Date thereof..... **April 10, 1947**  
(month) (day) (year)

Location..... **St. Michaels, Md.**

18. Funeral director..... **Newnam & Harrison**  
Address..... **St. Michaels, Md.**

19. Date rec'd by registrar..... **apl 9th 47**  
(Date rec'd by registrar) **Mrs. Poly. L. Seely**  
Registrar..... **St. Michaels, Md.**

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... **Maryland** County..... **Talbot**  
City or town..... **St. Michaels**  
(If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

**none**

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **April 8, 1947** 19..... at ..... 7: a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
Dead on arrival..... 19..... to..... 19.....

and that I last saw h..... alive on.....

Immediate cause of death.....  
**Lobar Pneumonia**

DURATION

6 days

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations..... **None** Date of op. .... **None**

Autopsy results..... **None**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....  Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, Industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE..... **F. B. Shears, M.D.** M. D. or other

Address..... **St. Michaels, Md.** Date signed 4-9-47

RECEIVED

APR 15 1947

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 107

01373

## CERTIFICATE OF DEATH

Reg. Dist. No. 595

## 1. PLACE OF DEATH:

County

City or town

Talbot

Easton, Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

all of life

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

Sophia Johnson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female. Colored Widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept. 14, 1876

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

70 7 12 hrs. min.

9. Birthplace

Tunsterville, Easton, Md.

(Town, county, and state)

10. Usual occupation.

Retired Cook

11. Industry or business

MOTHER FATHER

Zacharia Glassow

Queen Anne Co., Md.

13. Birthplace

Maria Skinner

14. Maiden name

Easton, Rural, Md.

15. Birthplace

John Cooper

16. Informant

Easton, Md.

Address

Burial

Date thereof Apr. 28, 47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory St. Stephens Churchyard

Location Tunsterville, Easton, Rural, Md.

18. Funeral director John D. Williams

Address Easton, Md.

19. 4/28 1947 71 1/2 hours

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

County

Street No.

County

Street No.

County

Street No.

County

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 1947 at 1:30 a.m.

21. CERTIFY that death occurred on the date above stated; that I attended deceased from April 22 1947 to April 26 1947 and that I last saw her alive on April 26 1947

Immediate cause of death

Pneumonia predominant 4-5 day

Due to

Streptoc. &amp; pneumonia &amp; Weather

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Hayward T. Webb, M.D. M. D. or other

Address

Easton, Md. Date signed 4/26/47

RECEIVED

MAY 3 1947

BUREAU C 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. (1) correct age  
is especially important. Physicians: please write the causes of death clearly and legibly.

01374

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1910

## CERTIFICATE OF DEATH

Reg. Dist. No. 211

## 1. PLACE OF DEATH:

County Talbot

City or town Neavitt

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Edwin L. Jones

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

male white married

B. (b) Name of husband or wife

Nannie B. Camper

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.)

Oct. 8, 1892

8. AGE: Years Months Days If less than one day

54 6 4 hrs. min.

9. Birthplace Neavitt, Talbot Co., Md.

(Town, county, and state)

10. Usual occupation Toll Collector

## 11. Industry or business

FATHER 12. Name Daniel E. Jones

13. Birthplace Neavitt, Md.

MOTHER 14. Maiden name Frances Bridges

15. Birthplace Bozman, Md.

16. Informant Mrs. Edwin L. Jones

Address Neavitt, Md.

17. Burial Date thereof April 14/47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery

Location Neavitt, Md.

18. Funeral director Newnam &amp; Harrison

Address St. Michaels, Md.

19. April 13 1947

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Neavitt

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

217-05-3714

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 12 1947

47 7 30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased

April 6 1947

47 7 44 PM

and that I last saw h. arrive on April 12, 1947 1947

19

Immediate cause of death

Acute Arteria

Schr. Nephritis

DURATION 2 yrs

Due to

Hypertension

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None

Date of op. None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.  Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other 441347

Address

Date signed

RECEIVED

APR 15 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01375

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:  
County Talbot

City or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 days

Hospital, Institution, or street address where death occurred  
Memorial Hospt. Talbot

How long in hospital or institution? 30 days

3. (a) FULL NAME

Baby Boy Kelly

4. Sex

M

5. Color or race

B

6. (a) Single, married, widowed, or divorced

S

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) March 6 1947  
8. AGE: Years 28 Months 30 Days 28 If less than one day 30 hrs. 0 min.

9. Birthplace Easton (Talbot Co.) Md.  
(Town, county, and state)  
10. Usual occupation Newborn

11. Industry or business  
FATHER 12. Name Charles Wright

MOTHER 13. Birthplace Easton Md.

14. Maiden name Aletina Kelly

15. Birthplace S.C.

16. Informant Hospital Records

Address Easton Md.

17. Burial Date thereof 4/5/47  
(Burial, cremation, or removal: Which?)

Cemetery or crematory Richards

Location Easton Md.

18. Funeral director Leon W. Kennedy

Address 310 South St Easton

19. Date rec'd by registrar 4/4/47 Date signed 4-4-47  
(Date rec'd by registrar) (Date signed)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md.County TalbotCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 3 1947 at 4 35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 6 1947 to April 3 1947and that I last saw him alive on April 2 1947

Immediate cause of death

Prematurity

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE W. F. Bell

M. D. or other

Address Easton Md. Date signed 4-4-47

RECEIVED

APR 9 1947

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 3d

01376

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County CalvertCity or town Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 day

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 3 day

## 3. (a) FULL NAME

James J. Kennedy4. Sex M5. Color or race C6. (a) Single, married, widowed, or divorced Widowed.B. (b) Name of husband or wife John7. Birth date of deceased (mo., day, yr.) Jan. 7-1874B. (c) If alive, give age years8. AGE: Years 73 Months  Days  If less than one day  hrs.  min. 9. Birthplace Rock Hall, Md.

(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

12. Name Wesley Kennedy13. Birthplace Rock Hall, Md.14. Maiden name Sarah Times15. Birthplace Rock Hall, Md.16. Informant Casteria WesleyAddress Rock Hall, Md.17. Burial Date thereof April 5-1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Chesapeake, Md.Location Chestertown, Md. R.D.18. Funeral director ad. bass. HenryAddress Chestertown, Md.19. (Date rec'd by registrar) 4/4 19. (Year) 47 N. H. Neeris  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty Kent CountyCity or town Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

Street No. 

(If rural, give LOCATION)

2.(a) If veteran, name war 

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 4-7-47

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar. 31 1947 to April 3 1947  
and that I last saw him alive on April 3 1947

Immediate cause of death

Cardiac failure  
bronchopneumonia - bilateral

Due to

Syphilitic  
tabetic aneurysmOther conditions Arterial occlusion  
anemia

(Include pregnancy within 8 months of death)

Major findings or operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? ..... (City or town) ..... (County) ..... (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE James J. Kennedy

M. D. or other

Address 2145 Rose St. East Date signed 4/7/47

RECEIVED

APR 11 1947

H. K. L. A. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. If incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 157

01377

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:  
County Talbot

City or town Easton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 hr.

Hospital, Institution, or street address where death occurred:  
Memorial Hospital

How long in hospital or institution? 1 hr.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Talbot, Md.

City or town Federalsburg  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 Main Street  
(If rural, give LOCATION)

2.(a) If veteran, name war.

3. (b) Social Security Number

3. (a) FULL NAME  
Baby Girl Liden

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced S

6. (b) Name of husband or wife.

7. Birth date of deceased (mo., day, yr.) April 3, 1947  
6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day  
1 hr. min.

9. Birthplace Easton (Talbot Co.), Md.  
(Town, county, and state)

10. Usual occupation Newborn

11. Industry or business

12. Name Garrett B. Liden

13. Birthplace Caroline Co.

14. Maiden name Rose Anne

15. Birthplace Kentucky

16. Informant Memorial Hospital

Address Easton, Md.

17. Burial, cremation, or removal. Which? Date thereof 4/4/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Memorial Hospital

Location Easton, Md.

18. Funeral director Memorial Hospital

Address Easton, Md.

19. (Date rec'd by registrar) 1947 22 St. Meier  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 3, 1947 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3, 1947 to April 3, 1947  
and that I last saw h.s. alive on April 3, 1947 to April 3, 1947

Immediate cause of death Prematurity 6 lbs 1 oz  
DURATION

Due to:

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank M. Andersen, M.D.

M. D. or other

Date signed 4/3/47

RECEIVED

APR 11 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Harrison

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

01378

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County

Talbot

City or town

Easton

How long in above place of death?

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?

7 hours

## 3. (a) FULL NAME

Robert E. Miller

4. Sex

M

5. Color or race

B

6. (a) Single, married, widowed, or divorced

M

8. (b) Name of husband or wife

Vigie B. Miller

7. Birth date of deceased (mo. day, yr.)

1884

6. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

63

hrs.

min.

9. Birthplace

Boyce - Talbot, Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

MOTHER FATHER

12. Name

Edwin Miller

13. Birthplace

St. Michaels, Md.

14. Maiden name

Garret Goldsborough

15. Birthplace

Boyce, Md.

16. Informant

Vigie B. Miller

Address

St. Michaels, Md.

17. Burial (Burial, cremation, or removal. Which?)

Date thereof

4/28/47  
(month) (day) (year)

Cemetery or crematory

St. Michaels

Location

St. Michaels, Md.

18. Funeral director

J. Brown

Address

St. Michaels

19. (Date rec'd by registrar)

1947

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland County Talbot

City or town

St. Michaels

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 25 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and then I last saw h..... alive on..... 19.....

Immediate cause of death

Heart disease

DURATION

?

Due to

Due to

Other conditions

Diabetes mellitus

?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

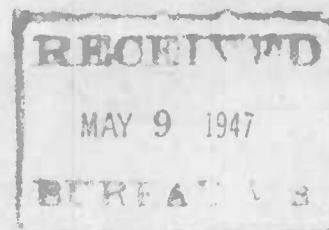
Means of injury

Injured at work?

23. SIGNATURE

Rexton Harrison M.D. M. D. or other

Address 317 E. Rose St. Easton Date signed April 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4

01379

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Talbot  
County.....  
City or town.....

(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Edward F. Newnam

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

male whitw widower

6. (b) Name of husband or wife Hazel Irene Jones

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age ..... years

July 14, 1887

8. AGE: Years Months Days If less than one day

59 9 4 hrs. min.

9. Birthplace Neavitt, Talbot Co., Md.  
(Town, county, and state)

10. Usual occupation Waterman

## 11. Industry or business

MOTHER FATHER 12. Name John S. Newnam

13. Birthplace Talbot Co., Md.

14. Maiden name Emma Shores

15. Birthplace Talbot Co., Md.

16. Informant Mrs. John T. Wayman Jr.

Address Neavitt, Md.

17. Burial Date thereof April 22, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery

Location Neavitt, Md.,

18. Funeral director Newnam & Harrison

Address St. Michaels, Md.

19. Apr 20 1947 Mrs. Betty S. S. Registrar  
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Talbot

City or town Neavitt  
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH 18 April 1947 5<sup>40</sup> P.M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 18 April 1947 to 18 April 1947

and that I last saw h. alive on unknown 19 47

Immediate cause of death Coronary thrombosis (presumptive) DURATION 3

Due to Heart disease (presumptive) ?

Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

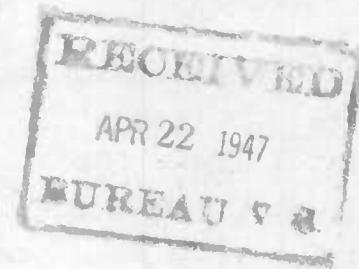
## Means of injury

Injured at work?

23. SIGNATURE

Dr. Herbert Morrison M. D. *Herbert Morrison*  
St. Michaels, Md. Date signed 19 Apr '47

Address



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

01380

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County DelawareCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death 37 yearsHospital, institution, or street address where death occurred: 113 Hanson Street

How long in hospital or institution?

## 3. (a) FULL NAME

Missouri Highti Person4. Sex Female 5. Color or race Col'd 6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife Alfred Person7. Birth date of deceased (mo., day, yr.) March -19 - 1870 8. (c) If alive, give age years8. AGE: Years 77 Months  Days 12 If less than one day hrs. 00 min. 009. Birthplace Hartford Co. Maryland (Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Hillie Bond13. Birthplace Maryland14. Maiden name Laura Virginia Berry15. Birthplace Maryland16. Informant Charlotte HoneyAddress 113 Hanson St.17. Burial Burial Date thereof 4-7-47 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location Easton, Maryland18. Funeral director Leon J. HenryAddress 114 S. Hanson Street19. 4/5 Date rec'd by registrar 19 47 D. H. Neerer Register

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty TalbotCity or town Easton

(If outside city or town limits, write RURAL and give nearest town)

Street No. 113 Hanson

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 2 1947 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1947 to April 2 1947 and that I last saw her alive on April 2 1947

Immediate cause of death

Bronchopneumonia

Due to

Due to

Other conditions

Rheumatoid Arthritis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

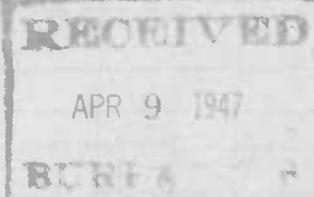
Means of injury

Injured at work?

23. SIGNATURE W. F. Bullard

M. D. or other

Address Easton, Md. Date signed 4/5/47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16

01381

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County TalbotCity or town St. Michaels

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charles P. Kinney

4. Sex

Male

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Mildred Pinkney6. (c) If alive, give age 25 years

7. Birth date of

deceased (mo., day, yr.)

March 1, 1925

8. AGE:

Years

Months

Days

If less than one day

22 1 19 hrs. min.

9. Birthplace

Annapolis, Anne Arundel Co.

(Town, county, and state)

Md.

10. Usual occupation

11. Industry or business

12. Name John Cooper13. Birthplace Talbot County14. Maiden name Christine Pinkney15. Birthplace Talbot County16. Informant Mildred PinkneyAddress Claiborne, Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof April 23 1947

(month) (day) (year)

Cemetery or crematory Claiborne CemeteryLocation Claiborne Maryland18. Funeral director J. Norman MarshallAddress St. Michaels, Maryland19. April 25 1947 Mrs. Bobbi L. Self  
(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty TalbotCity or town RehobethSt. MichaelsStreet No. ClaiborneMaryland

(If rural, give LOCATION)

2. (a) If veteran, name war

World War II

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

19 Apr

19 47

P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

19.....

and that I last saw h..... alive on

19.....

Immediate cause of death Bullet wound  
chest & perforation of heart

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results Infiltration of heart

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

HomicideDate of 19 Apr 47

Where did injury occur

H. L. Nichols(City or town) Talbot Maryland

(County)

(State)

Injured at home, farm, industry, public place (where?)

public placeMeans of injury shot

Injured at work?

23. SIGNATURE

Thurston Deamin L. D.

M. D. or other

Address 212 E. Rose St. Eastern MarylandDate signed Apr 26 1947

RECEIVED

APR 28 1947

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01382

## CERTIFICATE OF DEATH

Reg. Dist. No. 291

## 1. PLACE OF DEATH:

County.....

City or town.....

St. Michael

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 7 mos.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Milton Robertson

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M male

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

5/7/1946

8. AGE:

Years

Months

Days

If less than one day

10 24 hrs. min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

## 11. Industry or business

12. Name..... Milton Robertson

13. Birthplace..... Talbot Co.

14. Maiden name..... Elizabth M. Green

15. Birthplace..... Talbot Co.

16. Informant..... Mrs. Elizabeth Robertson

Address..... St. Michael MD.

17. Burial..... Date thereof..... 3/3/47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Unionville MD.

Location..... Talbot Co.

18. Funeral director..... Leon W. Henry

Address..... 310 South St. Easton MD.

19. 41 Date rec'd by registrar..... 1947

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Talbot

City or town..... St. Michael

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 1 1947 at 11<sup>00</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

dead on arrival to

and that I last saw h..... alive on 19

Immediate cause of death

Infantile Diarrhea

Due to..... Unetermined

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. 1

Autopsy results. ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. ✓ Date of

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

P. Breyer, M.D. or other

Address..... 515 Charles St. Date signed 4/2/47

Registrar



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1260

01383

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

## 1. PLACE OF DEATH:

County TalbotCity or town F. Eaton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Yrs. house

Hospital, institution, or street address where death occurred:

Memorial HospitalHow long in hospital or institution? 13 1/2 hours

## 3. (a) FULL NAME

Mrs Alice Sherwood4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married8. (b) Name of husband or wife John Sherwood7. Birth date of deceased (mo., day, yr.) June 27, 1860 8. (c) If alive, give age 80 years8. AGE: Years 86 Months 87 Days 9 If less than one day 22 hrs. 0 min.9. Birthplace Bozman - Talbot - Md. (Town, county, and state)10. Usual occupation H.W.

11. Industry or business

12. Name Benjamin McQuay13. Birthplace Bozman, Md.14. Maiden name Sarah D. Jones15. Birthplace Bozman, Md.16. Informant Mr. John KesperAddress Bozman Md.17. Burial Bozman Cemetery Date thereof April 27, 1947 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bozman CemeteryLocation Bozman Md.18. Funeral director Arnold & HarrisonAddress St. Michaels Md.19. 4/21/47 (Date rec'd by registrar) Jack. Neerius (Date signed) 22 April 1947 Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Bozman (If outside city or town limits, write RURAL and give nearest town)Street No. 100 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 19, 1947 at 3:45 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 April 1947 to 9 April 1947and that I last saw her alive on 18 April 1947 at 9 a.m. 1947Immediate cause of death Shock

DURATION

Due to Fract Simple Neck  
Right Femur

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

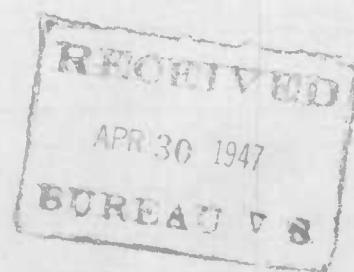
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of 18 April 1947Where did injury occur? Bozman, Md. (City or town) (County) (State) 18 April 1947Injured at home, farm, industry, public place (where?) HomeMeans of injury Fall Injured at work?23. SIGNATURE J. F. Kumanis M.D. M. D. or otherAddress F. Eaton Md. Date signed 22 April 1947



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

01384

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County

City or town

Talbot

Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

all of life

Hospital, institution or street address where death occurred

How long in hospital or institution?

## 3. (a) FULL NAME

Sarah Wilhelmina Smith

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female

White

Widow

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Nov. 1 - 1874

8. (c) If alive, give age years

8. AGE:

Years  
72Months  
5Days  
7

If less than one day

hrs.  
min.

9. Birthplace

Landing Neck, Easton, Md.

(Town, County, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

Robt. A. Glass

13. Birthplace

Caroline Co. Md

14. Maiden name

Anne Robinson

15. Birthplace

Talbot Co. Md.

16. Informant

Alfred Smith

Address

Easton, Md.

17. Burial

Date thereof Apr. 10 47

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Spring Hill Cemetery

Location

Easton, Md.

18. Funeral director

John D. Williams

Address

Easton, Md.

19. (Date rec'd by registrar)

4/8 1947

N.H. Morris

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

Talbot

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, same war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

April 8

1947

at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

November 1945 to April 1947.

and that I last saw her alive on April 5, 1947.

Immediate cause of death: Heart disease.

DURATION

3 yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 8 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Philip D. Williams

M. D. or other

Address

Easton, Md.

Date signed

4/10/47

RECEIVED

APR 16 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

01385

## CERTIFICATE OF DEATH

Reg. Dist. No. 1794

## 1. PLACE OF DEATH:

Talbot  
County.....  
City or town.....  
Tilghman

(If outside city or town limits, write RURAL and give nearest town)

8 months

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Sarah F. Waldron

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white widow

Charles B. Waldron

6. (b) Name of husband or wife.....

5. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) July 21, 1865

8. AGE: Years Months Days If less than one day  
81 8 22 hrs. min.9. Birthplace.....  
(Town, county, and state)  
St. Michaels, Talbot Co., Md.10. Usual occupation.....  
Housewife

11. Industry or business

12. Name..... Joseph Jefferson

13. Birthplace..... St. Michaels, Md.

14. Maiden name..... Susan Tarbutton

15. Birthplace..... St. Michaels, Md.

16. Informant..... Mrs. Newton George

Address.....  
Avalon, Maryland17. Burial..... April 14, 1947  
(Burial, cremation, or removal. Which?)

Date thereof..... (month) (day) (year)

Cemetery or crematory..... Olivet Cemetery

Location..... St. Michaels, Md.

18. Funeral director..... Newnam &amp; Harrison

Address..... St. Michaels, Md.

19. (Date rec'd by registrar) 4-13-47

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
Maryland  
State..... County..... TalbotCity or town..... St. Michaels  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... April 12 1947 of 80 years

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

April 10 1947 to April 12 1947

and that I last saw b..... alive on April 11 1947

Immediate cause of death.....

Cerebral Hemorrhage

Due to..... Hyperthyroidism

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings or operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

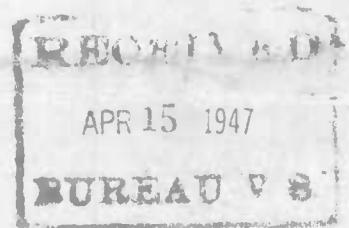
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... T. C. Loring Date signed 4-13-47



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-2

01386

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County.....

Talbot

City or town.....

Easton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

4 days

Hospital, institution, or street address where death occurred:

Memorial Hospital

How long in hospital or institution?.....

4 days

## 3. (a) FULL NAME

Ralph Walling

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

M

B. (b) Name of husband or wife.....

Mrs. June Walling

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

Feb. 17, 1868

8. AGE:

79

Years

Months

Days

If less than one day

..... hrs. ..... min.

9. Birthplace.....

New York

(Town, county, and state)

Farmer

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name.....

George Walling

13. Birthplace.....

New York

14. Maiden name.....

Mary Ball

15. Birthplace.....

New York

16. Informant.....

Address

Denton Md

17. (Burial, cremation, or removal, which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Buccard Jewelry

Location.....

Buccard Jewelers

18. Funeral director.....

Kirkwood Mausoleum

Address

Denton Md

19. (Date rec'd by registrar)

1947

(Date rec'd by registrar)

1947

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland

County.....

Caroline

City or town.....

Denton

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

April 5 1947 a 4/5 1947

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1, 1947, to April 5, 1947

and that I last saw h. m. alive on April 4, 1947

Immediate cause of death..... uremia

pyelonephritis

Due to..... Hypertrophied prostate

Due to.....

Other conditions..... chronic myocarditis

arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations..... large organized clot

in bladder

Date of op. April 2, 1947

prostate -

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

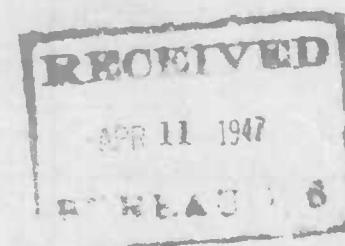
Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....

M. D. or other

Address..... Date signed.....



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct page is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1276

01389

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

7 hrs.

Hospital, institution, or street address where death occurred:

Memorial Hosptl &amp; Easton

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

M

W

Widowed

B. (b) Name of husband or wife

Mida Marie W. Houghbury

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

April 16, 1860

8. AGE:

Years

Months

Days

It less than one day

86 11 24

hrs. min.

9. Birthplace

Federalsburg, Caroline Co., Md.

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Richard James W. Houghbury

13. Birthplace

Federalsburg, Caroline Co., Md.

14. Maiden name

Elizabeth Alice Andrews

15. Birthplace

? Caroline Co., Md.

16. Informant

Mida Elizabeth Bettymore

Address

Preston, Caroline Co., Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

4/6/47 (month) (day) (year)

Cemetery or crematory

Springfield

Location

Preston, Md.

18. Funeral director

R. C. Clark &amp; Sons

Address

Easton, Md.

19. (Date rec'd by registrar)

4/5/47

19. 47

N. S. Neerup

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Caroline

City or town

Federalsburg

Caroline

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH April 4 1947 at 9:00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

4/6/47 1947 to 4/6/47 1947

and that I last saw him alive on 4/6/47

1947

Immediate cause of death

Jenna liged per trinita

DURATION

?

Due to

Rept fused gall bladder

?

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

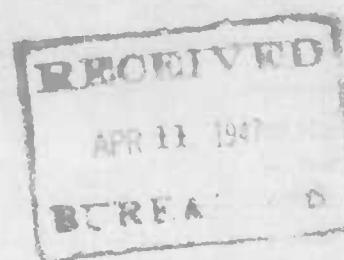
23. SIGNATURE

Ruthie Harrison M. D.

M. D. or other

Address 214 E. Love St. Catonsville Date signed 8/18/47

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. In the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 4621

01387

## CERTIFICATE OF DEATH

Reg. Dist. No. 290

## 1. PLACE OF DEATH:

County

Talbot

City or town

Easton - Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

8 years

Hospital, institution, or street address where death occurred:

Opposite

How long in hospital or institution?

## 3. (a) FULL NAME

Clarence J. Wilson

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Zena R. Wilson

## 7. Birth date of deceased (mo., day, yr.)

December 27, 1886

6. (c) If alive, give age 42 years

## 8. AGE:

Years 60

Months 3

Days 20

If less than one day

hrs. 0

min. 0

## 9. Birthplace

Queen Anne County, Maryland

(Town, county, and state)

## 10. Usual occupation

Clergyman

Methodist Church

Methodist Church

## 11. Industry or business

Henry Wilson

## 12. Name

Henry Wilson

## 13. Birthplace

Queen Anne County, Maryland

## 14. Maiden name

Martha Burgess

## 15. Birthplace

Queen Anne County, Maryland

## 16. Informant

Mrs. Zena R. Wilson

## Address

Easton, Maryland, R.F.D. 1

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

April 22, 1947

(month) (day) (year)

## Cemetery or crematory

Centreville Colored Cemetery

## Location

Centreville, Maryland

## 18. Funeral director

J. J. Frampton and Son

## Address

Federalsburg, Maryland

## 19. (Date rec'd by registrar)

4/21/47

1947

N.J. Morris

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Talbot

City or town

Easton - Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

Opposite

(If rural, give LOCATION)

## 2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH April 17, 1947, at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 1947 to April 17, 1947

and that I last saw him alive on April 17, 1947

## Immediate cause of death

Malignant Cancer

DURATION

3 mos

## Due to

ca of Cancer

## Due to

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings or operations

John Hopkins

Date of op. Sept 4, 46

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

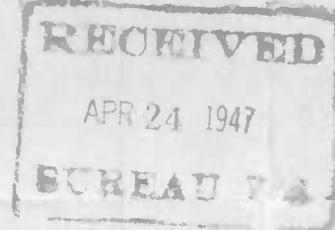
M. J. Burchell

M. D. or other

Address

Easton, Maryland

Date signed



Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

01388

ALM No. G 110 MAY 12 1947 CERTIFICATE OF DEATH

Reg. Dist. No. 290

1. PLACE OF DEATH:

County

Baltimore P.O. #1 Tunisville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

6 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

Frank Witzel

6. (b) Name of husband or wife

7. Birth date of  
deceased (mo., day, yr.)

8. (c) If alive, give age 50 years

8. AGE:

Years 62

Months 6

Days 0

If less than one day

hrs. 0 min.

9. Birthplace

Talbot Co. Md.

(Town, county, and state)

10. Usual occupation

Housewife

At Home

11. Industry or business

James Smith

FATHER

12. Name

Frank Witzel

13. Birthplace

Orlando

MOTHER

14. Maiden name

Anna Davery

15. Birthplace

Orlando

16. Informant

Burial

Frank Witzel (Husband)

Address

Baltimore, Md. P.O. #1

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof May 2, 1947

(month) (day) (year)

Cemetery or crematory

Spring Hill

Location

Baltimore, Md.

18. Funeral director

P. Ellis Clark

Address

Baltimore, Md.

19. #/30

(Date rec'd by registrar)

19. 47

M. H. Neirin

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

Maryland

County

Talbot

City or town

Baltimore

P.O. #1

Street No.

Tunis

Stiles

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH

April 29 1947 at 4 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

October 1946 to April 1947 and that I last saw her alive April 1947

Immediate cause of death Left ventricular failure DURATION 1/2 hr.

Due to Hypertension and irregular heart 7 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Shelburne S. Seymores M. D. or other

Address

Easton Md.

Date signed

May 1, 1947

RECEIVED

MAY 7 1947

BUREAU